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ORIGINAL ARTICLES

CYSTIC APPENDIX*

BY DR. WILLIAM P. DAVIS
PROVIDENCE, R. I.

Closely associated with the cystic degeneration of the ovary is the cystic degeneration of the appendix, presenting much the same signs and symptoms and making diagnosis almost impossible. In fact, due to the rarity of this condition, and its simulation to other conditions, I have been unable to find, in literature, one case diagnosed correctly as cystic appendix before operation or before post mortem.

The presence of the appendiceal cyst in itself is of little import, but complications arising therefrom are sufficient to give the condition more than passing thought and with this in mind, I have undertaken a short review of the literature on the subject.

In size, the appendiceal cyst may vary considerably. As a rule it is small but one has been reported to have reached the size of a man's head. (Boyd)

Formation of the cyst is thought to take place through gradual closure of the cavity of the appendix, generally at the caecum, by scar tissue or adhesions, plus the sterilization of the mucosa, lining the tract of the appendix distal to the obstruction. Gradual closure being necessary because sudden blocking of the lumen of the appendix has been found on experimentation, to produce gangrene though the circulation to the appendix has remained unchanged. And sterilization to prevent bacterial changes, slow drainage of the pathogenic organisms into the caecum taking place.

As the cavity of the appendix is shut off from that of the caecum, it becomes distended with mucus and a cyst of similar origin as the Hydrosalpinx is formed. The immediate cause may be obscure. Generally hydrops is primary with mild inflammation of the mucosa lining the tube. Later

the distension of the cyst is due to exudation of non-inflammatory nature and to atrophy of the mucous coat, such that no sign of inflammatory change may be found in the mucous lining.

Not always has there been found a complete obstruction between the appendiceal and caecal cavities and in these cases the contents of the cyst have been thick and tenacious.

Normally the secretion of the appendix is similar to that of the caecum, but as the cyst forms the secretion becomes serous, mucinous or pseudomucinous in character.

And where the cystic appendix is rare in itself, the serous type or hydrops, is extremely rare and I shall not pause to more than mention it.

Of interest I found one case of *Ecchinococcus Cyst* of the appendix reported in the *J. A. M. A.* by Brewer. A Chinese soldier, age 32, had had three attacks of abdominal pain in the past ten years. This attack, the fourth, of 24 hours duration consisting of severe epigastric colic, vomiting, deep tenderness over McBurney's point, no rigidity, T. 99.4 and WBC 13,800. At operation, the proximal half of the appendiceal cyst found was bound down to the ileo-caecal junction by peritoneum. The cyst was 8 cm. long and 1.5 cm. in diameter, smooth, white, distended, fluctuant and with possible hydated fremitus.

Upon opening the mass, there was found a cystic cavity with many secondary and tertiary cysts and extending from the tip to the narrowed base where the lumen was obliterated. Diagnosis was *Ecchinococcus cyst* of the appendix.

Most commonly found is the pseudomucinous cyst, the contents of which are mucinous in character, resembling mucin but not having the characteristic mucin reaction with acetic acid.

The diagnosis of cystic appendix may easily be confused with any of the surgical conditions related to the R. L. Q. Most frequent being ovarian cyst, acute appendicitis and appendiceal abscess.

Generalized conditions such as influenza and typhoid fever must be excluded.

Since the cystic appendix follows so closely other conditions of the appendix, I may quote Zachary Cope—"To catalogue the diseases which

*Read before the Memorial Hospital Staff.

may simulate or be simulated by appendicitis is to enumerate all the chief acute abdominal diseases." The same may well be stated concerning cystic appendix.

The signs and symptoms follow those of appendicitis. Pain in the R. L. Q., vomiting, nausea, anorexia and localized tenderness. There may be repeated attacks.

In uncomplicated cases there is less likelihood of elevation of temperature or pulse or of muscle spasm and due to the palpable mass present in a number of cases the diagnosis has been confused with that of ovarian cyst.

Now if the diagnosis is not made nor operation carefully performed, in time the thin walls of the pseudomucinous cyst may rupture, spilling its contents into the peritoneal cavity, generally unaccompanied by symptoms denoting the change in conditions.

The cystic contents become implanted on the peritoneum producing proliferation with formation of large masses like frog spawn, covering the visceral and parietal peritoneum—*pseudomucinous-peritonei*. This is probably due to the implantation of epithelial cells on the peritoneal surface where they produce mucinous secretion.

The peritoneum reacts forming a fine pedicle of fibrin over the mucoid material which organizes to a thin vascular membrane. Fine fibrous septa are sent up by the peritoneum between the lobulations of the masses. The abdominal organs may all be covered and the omentum surrounded and infiltrated producing the broad thick "Omental cake."

The prognosis of pseudomucinous peritonei is very unfavorable for the majority of cases are fatal though the condition is of long duration. The origin is more frequently from cystic ovary than from cystic appendix due to the rarity of the latter and when arising from cystic appendix there have occurred more cases in men than in women.

The first case reported was found at P. M. by Frankel in 1901. In 1910 Trotter published the tenth case, only two patients having recovered in these ten cases.

The treatment consists of repeated opening of the abdominal cavity and of washing out the abdominal cavity with saline in the attempt to remove as much of the pseudomucinous material as possible.

The cyst may become a *mechanical* factor in the production of a surgical abdomen as may be illustrated by a case reported by Dubs.

The condition of this patient before operation was considered very poor.

The abdomen was opened and found to contain 1½ liters of stinking hemorrhagic fluid. A huge convolution of bluish-black intestine filled the wound. Immediately joining the caecum was found about four inches of normal ileum and then obstruction. Wound around the obstructed loop of ileum and provided with an extensive pedicle which connected with the middle third of the appendix was found a cyst so located as to cause the obstruction. And about this strangulated loop of ileum as a turning point an extensive volvulus of the small intestine had occurred which involved the entire ileum and a portion of the jejunum. Collapse of the patient rendered inadvisable such extensive resection. However the appendiceal cyst was removed and found to be pseudomucinous in character.

A very interesting case of pseudomucinous appendiceal cyst was reported by Bailey of St. Louis in 1916.

A male, 25 years of age, was well until one year previous to this history when he was taken ill with an attack of acute appendicitis and at operation it was found that the appendix had ruptured. Nothing was done further than drainage and he made an uneventful recovery. However the sinus formed continued to discharge at intervals and he developed attacks of pain in the R. L. Q. associated with anorexia, loss of weight and constipation.

Upon examination he presented tenderness over the entire right side exaggerated over the scar from the previous operation and spasm of the right rectus muscle.

In the sinus was an exudate containing flakes of gelatinous appearing material. The appendix was located and found to be large, doubled upon itself and fixed by bands which constricted it just proximal to its tip which was markedly distended. Closely associated to the appendix was a large omental tumor. The bed of the appendix was filled with about 2 oz. of gelatinous substance. Upon dissection it was found that a smooth walled tumor mass projected from the append. between the layers of the mesenteriole, thin and fluctuant.

This mass was found to be a cyst containing gelatinous material which communicated with the distended portion of the tip through a narrow opening. The lumen of the remaining part of the appendix was obliterated. The lining of the cyst was similar to that of the distended portion of the appendix. No pseudomucinous material was reported at the previous operation.

I have been able to find but one case of cystic appendix from the records of the Memorial Hospital, which case I am reporting after gaining permission from Dr. Moore upon whose service the patient was admitted and was operated.

I have searched through the files of the Rhode Island Hospital and have failed to find one single case of similar condition.

PSEUDO-MYXOMATOUS CYST APPENDIX

Case Report.

An American housewife, age 32, was admitted to the Memorial Hospital, Pawtucket, R. I., on Aug. 22, 1926, with the diagnosis of Chr. Appendicitis and cystic ovary.

Her chief complaint is pain in the Rt. side of her abdomen.

Her family and past histories are neg. with the exception that she has one brother who is living but is suffering from tbc, with whom she has associated considerably. She has had night sweats but not for some time. She has had the usual childhood diseases, gripe every winter and erysipelas 1 yr. ago.

For the past 9 yrs. she has had recurrent attacks of pain in the right side. 8 wks. ago had a severe attack which lasted 1½ wks. 3 wks. ago the attack again recurred with nausea. The pain has continued on and off daily since then, having pain many times during the day, the severity proportioned to the activity of the patient and seems to think the pain to be lessened after eating. No vomiting except on the first day of her attack but frequently nauseated, especially in the morning. Bowels regular.

Physical examination presents a well developed and nourished white woman lying comfortably in bed without apparent distress. There is a fetid odor to the breath. Chest is negative. Abdomen scaphoid, slightly tense, no spasticity, no masses but marked tenderness over McBurney's point.

Vaginal examination: bilateral cervical tear with much enlargement of anterior lip. Cervix freely

movable. There is definite enlargement in the region of the right appendages. Pt. is mensesruating. Temp. and pulse are normal. Urine neg.

Aug. 26, 1926, 4 days after admission at which time a D. & C., amputation of the cervix and perineal repair was done, the abdomen was explored. "On opening the abdomen, a large sausage like mass appeared which at first looked like a diverticulum. The mass was found to be an appendix, position as usual but caecum was covered with a thin (apparently congenital) fold of mesentery. Rt. ovary, tube and broad ligament were adherent to the mesentery of small gut. Appendix tense and fluctuant and appeared to be full of fluid. Mass was about 3 inches long and about the size of a man's thumb. The base was broader than usual but smaller in diameter than the rest of the appendix. Appendix removed in the usual manner.

The appendix was opened after operation and the lumen was found to be distended with a transparent glairy mucilaginous substance which did not flow, retaining the form of the distended lumen. The proximal portion of the lumen at the base was obliterated.

Report from the pathological laboratory was cystic appendix.

The patient made an uneventful recovery and was discharged well Sept. 9, 1926.

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CHRONIC ULCERATIVE COLITIS*

CECIL C. DUSTIN, M.D.
PROVIDENCE, R. I.

For many decades, investigators have searched for the etiology of colitis, and a mass of literature on the subject has accumulated. A review of this

*Read before the Amos Troupe Club, May 10, 1927.

material is not entirely satisfactory, because of the confusing terminology, and even now physiologists are not entirely agreed upon the normal physiology of the colon, and it must necessarily follow that there is a corresponding confusion regarding the pathology of this portion of the gastro-intestinal canal. During the last decade much progress has been made in the study of chronic ulcerative colitis, probably because of the more general use of the proctoscope and sigmoidoscope, and a better use of the X-ray in studying the colon.

The chronic infectious processes such as tuberculous enteritis, amoebic and bacillary dysentery and actinomycosis of the colon are well understood, but the etiology of the so-called idiopathic ulcerative conditions of the colon is less well known.

In 1924 Bargen^{1, 2} at the Mayo Clinic announced the discovery of a micro-organism which he believes is the cause of ulcerative colitis. He observed a large series of cases in various stages of the disease and has demonstrated quite conclusively that the ulcerations are the immediate result of miliary submucous abscesses, and from these abscesses he has been able to isolate repeatedly the organism which he believes responsible.

There is considerable evidence that points towards a much more complex etiology for the disease. Probably the majority of cases of ulcerative colitis remain undiagnosed until the disease has progressed for some time. The disease has a decided tendency to run in cycles, with definite exacerbations and remissions. The patients are almost invariably "finicky eaters," and a careful history will reveal a grotesque and often pernicious dietary habit extending over a long period of time.

McCarrison^{3, 4, 5} was able to produce ulcerative colitis, among other gastro-intestinal lesions, by feeding deficient diets. By feeding faulty diets over varying periods of time he was able to produce in monkeys and men, diarrhoea, dysentery, dyspepsia, and gastric dilatation, gastric and duodenal ulcers, intussusception, colitis, and failure of colonic function. He does not contend that these conditions are invariably produced by faulty diet, but he does believe that faulty food is often at the bottom of their causation and if natural, well balanced foods were used from birth their occurrence would be lessened. Some of his conclusions regarding his experiments are as follows:

Adequate provision of vitamins is essential for the health of the gastro-intestinal tract.

The absence of growth vitamins is capable of producing pathological changes in the tract which frequently assume the clinical form of colitis.

Deficiency of vitamin C is especially concerned in the production of congestive and haemorrhagic lesions in the tract, and evidence of these may be found in animals which have not shown, during life, any of the clinical signs of scurvy in any notable degree.

A state of ill health of the gastro-intestinal tract may therefore be a pre-scorbutic manifestation of disease due to deficiency of this vitamin, especially when associated with an excess of starch or fat, or both, in the diet.

An impairment of the protective resources of the gastro-intestinal mucosa against infecting agents, due to hemorrhagic infiltration, to atrophy of lymphoid cells and to imperfect production of gastro-intestinal juices, may not only result in infections of the mucous membrane itself, but also passage into the lymph and blood streams of micro-organisms from the bowel.

In this connection it is interesting to note the occurrence of gastro-intestinal pathology in some of the known deficiency diseases, as: scorbutus, rickets, pellagra and primary anemia; the recent investigations seem to place the latter disease in this class.

The part played by colonic stasis, from any cause, must not be overlooked. The improper diets mentioned favor constipation from their deficiency in vegetable matter, and it is impossible to estimate whether the faulty diet or the resulting constipation is more important in favoring the ulceration.

The symptoms in chronic ulcerative colitis are very varied. It is erroneously believed by many that diarrhoea is the most notable symptom. Probably persistent diarrhoea is only a late manifestation. Cabot and Emerson⁶ reported diarrhoea in less than half the cases studied, and constipation occurred in severely ulcerated cases. Perhaps this should be expected from the analogy of typhoidal and tuberculous ulcerations which produce in the majority of cases constipation rather than diarrhoea. In only 17% of the 1,495 cases analyzed by McCrae in Osler's "Modern Medicine" was diarrhoea present, though in every case presumably the intestines were extensively ulcerated. Kantor^{7, 8} in a recent article has stated that colitis

simulates appendicitis, cholecystitis, gastric and duodenal ulcer, cancer and cardiac disease, depending upon the segment of the colon involved. In my experience tenderness along the colon, particularly in the sigmoid and descending portions, is nearly always present. Of course tenderness in the right hypogastrium or right iliac fossa is very apt to divert the attention from the colon, and unquestionably pain in these regions from colitis, makes the diagnosis more difficult.

Although there is seldom gross blood in the stools, early in the disease, in the majority of stools examined, chemical blood is present and red blood cells can be found microscopically in a freshly passed stool. During the acute exacerbations, when the ulcerations are more extensive, there is usually a period of loose movements, which show pus, blood and an increased amount of mucus.

The roentgenologists are not entirely agreed upon what, from the X-ray examination, permits a diagnosis of colitis. Kantor^{7, 8} feels that a positive X-ray diagnosis is possible, but in his papers upon the subject he does not state that the X-ray diagnosis has always been checked by proctoscopy and stool examination. The X-ray findings are, of course, dependent upon a disturbed physiology of the colon, and it is doubtful if the diagnosis of ulcerative colitis can be made definitely, by X-ray examination, alone, at least, with our present knowledge of the disease.

Direct observation of the mucous membrane of the rectum and sigmoid colon is not difficult, and properly carried out need not be painful, and it leaves no doubt as to the condition of these portions of the colon. The ulcerations are by no means confined to the rectum and sigmoid, but they are present here in a large proportion of the cases, and unquestionably more frequent examinations by proctoscope and sigmoidoscope will lead to a higher percentage of accurate diagnoses.

The appearance of the mucosa will depend upon the stage of the disease at which the examination is made. If seen early, or at the beginning of an exacerbation the mucosa is hyperemic, has a granular appearance and does not have the smooth, glistening surface of the normal membrane. A little later small yellow patches will appear. These are the submucous abscesses which are the beginning of the ulcerations. When well advanced the entire rectum and sigmoid will have almost the

character of one large ulceration, bleeding wherever it is touched. As the process heals, either spontaneously or following treatment, there is a gradual extension of the mucous membrane and ulcers then show the deep, sharply defined character. Usually the mucosa between the ulcers shows scarring, and has a peculiar mottled appearance. After the process has healed entirely, the mucosa will still show a mottled marking, the sites of the ulcers being a little lighter than the surrounding areas.

In the chronic cases the mucosa takes on an atrophic appearance, from the repeated ulcerations and the resulting scarring.

The treatment of the disease, until the last few years, has not been very satisfactory. The disease is essentially chronic, probably more chronic than is at present realized, and, as in most chronic diseases, the treatment must be kept up over a long period of time. From reviewing the literature it seems that more attention has been given to the dietary during the past decade, and the efficiency of treatment has improved. Logan⁹ has reported encouraging results from vaccines prepared from the organism isolated by Barger, although a sufficiently large number of cases has not yet been reported to allow for a proper valuation of this method of treatment. Most of the investigators recommend non-irritating diets, and a study of these shows them to be vitamin rich, and it seems that this is a very important step toward rational treatment.

I am impressed by how little we really know of what constitutes a proper diet. Most investigators now designate the accessory food factors as vitamins A, B, C, D, and probably a fifth, E. These are all apparently necessary for the proper development and growth of the young, but their investigation in regard to the nutrition of adults has not progressed very far.

Vitamin A occurs in large amounts in butter, cream, cod-liver oil, and in small amounts in some other animal fats. Egg yolk is rich in this vitamin. It is found in moderate amounts in most cereals and grains, but not in white flour or polished rice. It occurs to a small extent in a few of the fruits, particularly oranges, and still more in tomatoes. Practically all the green vegetables contain it, particularly spinach, while white potato, endive, cabbage and cauliflower contain but little. There is none in yeast.

Vitamin B is water soluble, and often vegetables are robbed of this food factor by boiling, when the cooking water is thrown out. The sugars contain none, fats, cereals and grains very little; glandular meats contain a little more and it is abundant in certain fruits, as citrous fruits, and tomatoes. Apples and pears contain a little, and large amounts are found in beans, raw cabbage, fresh spinach and yeast, and moderate amounts in almost all the fresh greens and vegetables and nuts. It is present in milk and milk products.

Vitamin C is present in many of the food products, but the most common and plentiful sources are: citrous fruits, tomatoes, raw cabbage, carrots, lettuce, onions, turnips. It is variable in milk and milk products, and there is probably none in animal protein foods and dried grains and cereals.

Vitamin D apparently has to do with calcium metabolisms, and is known to occur in cod-liver oil, and vitamin E is believed to influence the metabolisms of iron.

There is evidence that modern methods of cooking and preserving foods in most instances destroys the vitamins or decreases their efficiency. Canned tomato, and condensed and evaporated milk are notable exceptions.

From this brief review it is quite easy to understand how one can take, either through circumstance or ignorance, a deficient diet, over a long period of time; and this can probably more readily occur among the well-to-do than among the poor, because the latter must for economical reasons use more of the coarse vegetables and dried legumes.

A general anti-deficiency diet, either for prevention or cure, must contain, first, fresh food, neither too old nor sterilized by heat; it must contain foods known to be rich in vitamins; and lastly, it should contain fresh animal fats, preferably butter. Such a diet would include fresh fruit and fresh vegetables; fresh meats; and legumes fresh or dried (not canned), peas, and beans; flours made by undermilling the grains, or whole grain flour.

A diet of this nature will also do much to overcome the constipation which must be corrected if normal colon function is to be restored.

On the whole, drug therapy has not been very satisfactory, and for the most part is symptomatic.

Colonic irrigation is not as popular as in years past and, when used, probably a simple saline is most satisfactory. Local applications by rectum may relieve some of the pain and tenesmus during the exacerbations and promote healing in the more stubborn ulcers.

The following is a report of a case of chronic ulcerative colitis:

R. P. First seen in March, 1925. Age 17.

P. I. For six years she had been having periodic attacks of diarrhoea, accompanied by marked anemia and weakness. The diarrhoea was intermittent with constipation. She had spent nearly half her time, since the onset, in convalescent homes and hospitals. While at home, between the visits to the hospitals, she lived chiefly upon a diet of cocoa and bread, generally without butter.

Her past history was unimportant except that domestic conditions had made it possible for her to choose only such foods as she desired, and she had always eaten mainly starches, with very little fat and protein, and almost none of the vitamin carrying foods.

Upon examination the general condition was not remarkable except for the examination of the blood, and the rectum and sigmoid. The blood showed an erythrocyte count of 4,200,800, with a haemoglobin of 40, otherwise normal.

By proctoscopy and sigmoidoscopy, the lower rectum was filled with what appeared to be excess granulation tissue, which bled easily. At the level of the third rectal valve there was an annular constriction which just allowed the passage of the 2 cm. tube. Above this as far as could be seen the mucosa showed numerous shallow ulcerations. Swabbing from the ulcers showed no amoeba or other evidence of intestinal parasites.

The Von Pirquet was negative.

The stools showed pus and blood, with a very slight increase in mucus.

Tissue removed from the rectum showed only a chronic inflammatory condition.

The patient was put on a well balanced diet, rich in vitamin and roughage, which she took well.

Three weeks later, about April 1, she showed an erythrocyte count of 4,816,000, and haemoglobin of 55%. Proctoscopy showed practically no ulceration of the sigmoid and rectum. The mucosa of the rectum was hyperemic, but otherwise was not abnormal. The annular constriction was unchanged, and was thought to be due to repeated

ulceration during the previous years of the disease.

During the next three months her haemoglobin rose to 72%, with a normal erythrocyte count. The rectal mucosa showed no hyperaemia and the stools were normal.

She did not return again for two months, and then showed a haemoglobin of 65, and a slight reduction in erythrocytes. Upon questioning her carefully it was learned that she had given up the prescribed diet, and had returned to the bread and cocoa, with a few apples which a neighbor had told her would cure her condition. She showed numerous ulcers of the rectal and sigmoid mucosa.

She was persuaded to again take up the prescribed diet, and in a month had a normal blood picture, and went to work in a textile mill. When last seen in November, 1926, she was apparently well, and was following her prescribed diet.

This case illustrates the chronic, recurrent tendency in the ulcerative colitis, and it seems to indicate that a poor dietary had much to do with its causation, and cure followed a regulation of the diet.

SUMMARY.

Ulcerative colitis is a chronic disease which has a tendency to remission, and is often undiagnosed until in its late stages.

Those afflicted with the disease are almost always people of long-standing poor dietary habits.

Although the immediate cause of the ulcerations is likely infectious in origin, there is experimental and clinical evidence which supports the idea that the disease is fundamentally a deficiency disease.

The most helpful aid in diagnosis is proctoscopy and sigmoidoscopy.

Drug therapy is of value in relieving symptoms, vaccine therapy is apparently a valuable adjunct, but dietary regulation seems to offer most in the treatment of the disease.

Cases diagnosed early apparently have a good prognosis.

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ISOLATION OF AN ORGANISM FROM THE BLOOD WHICH RESEMBLES THE PATHOGENIC YEASTS AND MOLDS, WITH A DISCUSSION OF THE DISEASES CAUSED BY THE LATTER.

BY LUCY ELIZABETH BOURN, M.D.
PROVIDENCE, R. I.

Case History and Laboratory Findings

On December 14, 1918, M. L. J., a girl eight years old, was admitted to the Albany Hospital "with symptoms of an acute appendicitis with perforation. A mass could be felt distinctly in the right hypochondrium. At operation the same evening, the appendix was found acutely flexed with distal half of the organ gangrenous and perforated. The inflammatory mass was well protected with omentum. A small amount of pus was found and evacuated. Drainage was instituted and the patient placed in a semi-reclining position. Later the patient was found to be suffering with typhoid fever." The clinical diagnoses made were acute perforated appendicitis, localized peritonitis, and typhoid fever. Histological examination of the appendix removed at operation showed acute appendicitis with perforation.

On the fourth day after the operation, the patient began to complain of some abdominal pain. Her evening temperature on this day and the succeeding day was 102°F. During the following four days it rose to 104°F., and remained high during the following week. A white blood count taken on the eighth day showed 28,000 cells per cu. mm.

On the twelfth day after admission, the patient was put in isolation. The following day the patient's blood serum gave a Widal reaction which was only suggestive of a positive reaction for B. typhosus. The same was true of the next day's specimen, at which time the white blood count was still high, namely 18,500 cells per cu. mm.

On the fifteenth day a culture from an abscess of the appendectomy wound was negative for *B. typhosus*. On the sixteenth day the patient's stool was examined for typhoid bacilli with negative results. The blood serum again was only suggestive of a positive Widal reaction for *B. typhosus* and negative for *B. Paratyphosus A* and *B.*

On the eighteenth day a blood culture was taken. Upon 48 hours incubation, the broth flask developed a white mold colony, which increased in surface growth until a firm pellicle was formed over the free surface. Upon 96 hours incubation, mold colonies appeared on one of the agar plates. The urine culture of this date proved negative for *B. typhosus* also, and the white blood count was 12,900 cells per cu. mm.

On the twenty-fourth day another blood culture was taken. Again upon 48 hours incubation the mold appeared in the broth flasks, while each of three of the agar plates and the bile broth showed the mold growth after 96 hours incubation and on the following day the fourth agar plate also showed the mold. Control flasks of broth which had been opened in the room where the blood cultures were taken remained sterile.

On the twenty-fifth day the patient's blood serum reacted strongly enough with *B. typhosus* to be reported as a positive Widal for *B. typhosus*. On the twenty-sixth day the patient's white blood count was still high, being 9,900 cells per cu. mm. On the thirty-fifth day the patient was discharged as recovered.

Experimental

Since upon two different occasions the same organism was recovered from the patient's blood, it was thought advisable to test the pathogenic powers of the organism by animal inoculations.

On January 28, 1919, two white rats were inoculated with 1 cc. each of an emulsion of the growth from an agar slant. At the end of two months one of them was killed, although not apparently ill. On autopsy, nodules were found in the abdominal wall, liver, omentum, diaphragm and lungs. The organism was recovered in cultures from nodules in the omentum and abdominal wall after six days incubation. Rat No. 2 was killed June 10, 1919. On autopsy, nodules were found in the omentum and the mediastinum. No growth was recovered from these lesions nor from the heart's blood. A

histological study of these lesions was made and will be mentioned later.

Discussion of Blastomycosis and Sporotrichosis

In 1894, Busse in Europe and Gilchrist in America both isolated and studied the organism now recognized as the etiologic factor in blastomycosis. This disease has also been described under the names oidiomycosis and saccharomycosis. The published studies of Busse and Gilchrist are the first on this subject.

"Blastomycosis is typically a subacute or chronic infectious process, usually pulmonary at the onset, but characterized sooner or later by the development of subacute abscesses, few or numerous, localized or widely dispersed over the body and often involving the bony structures, joints and surrounding soft tissues. Pulmonary lesions are at times pneumonic in type, but ultimately are proliferative, suppurative, and destructive, and give many of the signs and appearance of tuberculosis."

By far the greatest majority of cases are found to have occurred in previously healthy adult males, usually living in reduced circumstances. The majority of cases have been reported in Illinois, in Chicago especially, although cases have been reported from all parts of North America, as well as South America, Europe and the Orient. In 1916, 53 per cent. of the North American reported cases were from Chicago, which may be accounted for by any one or all three of the following reasons:

1. Endemic establishment of a particularly pathogenic fungus there.
2. Crowded unhygienic living conditions, especially in winter.
3. Unusual efficiency of medical profession in recognition of the condition and interest in it.

Stober made a study of the living conditions in a number of Chicago's cases, from which he concluded that the molds found in these places point insistently to the adaptability of such fungi to parasitic life in the animal body.

Initial onset in the majority of cases reported are designated either by pulmonary symptoms (cough, expectoration, etc.) or cutaneous or subcutaneous abscesses. This has led some students of the disease to classify the cases as Surgical Blastomycosis and Systemic or Generalized Blastomycosis. Under surgical treatment and potas-

sium iodide, recovery is often made if it is started early. The systemic type is refractory to treatment and recovery is seldom made, death occurring from exhaustion or some intercurrent infection.

The mode of extension of the disease from skin lesions is apparently by way of the blood stream, as lymphnodes are rarely affected and isolation of the organism from the blood stream has been accomplished.

In 1916, Wade and Bel summarized the necropsy findings in the 47 reported North American cases. The distributions of lesions were found to occur in the following organs in diminishing involvement: lungs, skin, bone, spleen, kidneys, liver, lymphnodes (brain, meninges, etc.), pleura, prostate, retropharynx, heart, peritoneum, pancreas, adrenals, muscles (without other involvement), larynx, pericardial cavity, intestines, epididymis, eye, tongue, tonsils, trachea, esophagus, diaphragm and testicle.

It may be added that in one case at least the lesion was found in the appendix.

Case Findings Bearing on the Case in Question

In 1908, Montgomery and Ormsby published a survey and summary of 22 cases. In two of these cases, blastomycetes was isolated in blood cultures, in three cases the organisms were seen in sections of blood vessels, in five cases it was isolated from the feces in which diarrhea was noted, in five cases from the urine. In eight cases there was more or less leucocytosis, and anemia in four, in two an enlargement of the spleen and in one enlargement of the liver.

In 1872 Popoff inoculated dogs with impure yeasts and obtained septicemic and typhoid conditions, miliary tubercles in the viscera, but blastomycetes were not demonstrated in them.

In 1909, Fontaine, Hasse and Mitchell report a case of systemic blastomycosis with initial pulmonary symptoms in which in the second week the blood serum gave a positive Widal reaction. This substantiates, according to these authors, the findings of Collins, who with repeated inoculations of brewer's yeast into rabbits and goats produced agglutinins in their blood for *B. typhosus* and allied organisms of the dysentery group.

Histological Findings

"The typical so-called blastomycetes in the tissue lesion does not produce mycelia and does not

form ascospores, but appears and persists in the form of more or less sclerotic, yeast-cell-like bodies which multiply entirely by budding. Isolated and cultivated artificially, it appears usually to be a mold of saprophytic type, growing at room temperature rather more readily than at 37°C., and usually very luxuriantly on bread and potato. Typically it quickly ceases to grow in toruloid form and finally produces a white cottony mycelium."

The histological picture presented in the lesions produced in the animals inoculated with cultures from the case in question and animals inoculated with a similar culture isolated from the urine of a Japanese patient by Dr. Graham is identical with those described by the various students of Blastomycosis and Sporotrichosis. It simulates the military tubercle and consists of fibrous tissue surrounding areas of necrosis which in addition to cellular detritus and exudate show innumerable yeast-like bodies, some of which are budding. Numerous giant cells are also present, some of which include the organism.

Sporotrichosis is the name applied to the second of the best known diseases due to pathogenic yeasts or molds. It is closely related to blastomycosis, but more seems to be definitely known about this disease. The first sporotricha pathogenic for man was studied and reported by Schenck at Johns Hopkins in 1896. In 1917, eighty-five American cases had been reported, fifty-three of which were proved by culture. It is a chronic infection characterized by cutaneous and internal lesions. The internal lesions are rare, and the cutaneous lesions are most commonly found on the fingers, hands, arms, lower extremities, head and eyes. The probable routes of infection are by way of the lymph and blood streams. Infection is usually found to follow the bite of a horse, mouse, hen or wire injury, etc. In sporotrichosis infections, antibodies of various kinds are readily generated, which is in marked contrast to blastomycosis, the closely related disease in which antibodies are apparently generated with great difficulty or not at all.

Davis has obtained repeated positive sporo-agglutination tests with serum dilutions varying from 1-320 to 1-80 which parallel the clinical course of the disease. Positive complement fixation tests parallel the agglutination tests. The

antibodies retain their activity in the ice-box for over a year. With various strains of antigens used, apparently like results were obtained, which points to the identity of different strains. Intracutaneous tests with French and American strains both gave strongly positive reactions.

Blastomycetic antigen did not cause this reaction nor did a patient suffering from blastomycosis react to the sporothricosis antigen.

The antigens are stable, resist heat, remain active for over a year, and potassium iodide treatment does not appreciably alter their sporothricosis reaction.

The histological picture presented by the sporotricha is the same as that presented by the blastomycetes.

Conclusion

There is much that a more complete history of the case might add as a means in aiding one to draw more definite conclusions. It seems, however, from the history presented, and in view of the findings, both clinical and experimental, of the reported cases studied, that this case presented very little on which to base a diagnosis of typhoid fever following acute perforative appendicitis.

On the other hand, no case of recovery from a systemic infection has been reported. This does not exclude, however, such a possibility, for comparatively few cases have been studied, and they have not come to the physician's attention early in their course. It is safe to conclude; therefore, I believe, that infections of this type go by unnoticed, and when accidentally found, are not recognized as such, the organism isolated being looked upon as a contaminant.

In view of these probabilities, either one of two causes may have led to the findings of the organism in the blood of the case in question:

1. It may have been the cause of the acute appendicitis.

2. It may have resided in the appendix as a non-pathogen and escaped into the blood stream with the suppurative and fecal materials upon perforation of the appendix, there setting up a rather severe infection for the time being.

ANNOUNCEMENT

The American College of Surgeons will hold the seventeenth Clinical Congress in Detroit, Oc-

tober 3-7. Headquarters will be at the Book-Cadillac and Statler Hotels, and the meetings will be held at the Statler Hotel, and Orchestra Hall. The Hospital Standardization Conference will extend from Monday morning to Thursday afternoon and will include a discussion of hospital and nursing problems and hospital demonstrations. Monday evening's program will include an address of welcome by the local chairman, the address of the retiring president, the inaugural address of the new president, and the John B. Murphy oration. Clinics in general surgery will be held in the Detroit hospitals each morning from Tuesday to Friday, and in eye, ear, nose and throat work the same afternoons. Clinics will also be held at University Hospital, Ann Arbor, Tuesday to Thursday. On Tuesday and Wednesday mornings and afternoons, and on Thursday morning, clinical demonstrations will be held at the Statler Hotel (mornings) and Orchestra Hall (afternoons). On Thursday afternoon the annual meeting of the Governors and Fellows will be followed by a cancer symposium. On Friday afternoon there will be a symposium on traumatic surgery, to be participated in by leaders in industry, labor, indemnity organizations, and the medical profession. On Tuesday evening the program will take the form of a celebration of the Lister Centennial. On Thursday evening there will be a large Community Health Meeting in the Masonic Temple, and on Friday evening the Annual Convocation of the College. Other outstanding features will be the exhibits. In addition to the commercial exhibits there will be a replica of the Lister exhibit at the Wellcome Museum of Natural History, London, including Lister's operating rooms and hospital wards. The departments of hospital activities, of literary research, and of clinical research of the College will also present exhibits. Among the foreign guests will be Sir John Bland Sutton, England; J. M. Munro Kerr, Scotland; Gordon Craig, Australia; Gustaf E. Essen-Moller, Sweden; S. A. Gammeltoft, Denmark. The retiring president is W. W. Chipman, Montreal, and the president to be inaugurated, George David Stewart, New York. The Lister oration will be delivered by W. W. Keen, Philadelphia. The chairman of the Detroit committee on arrangements is Alexander W. Blain.

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ARTHUR H. HARRINGTON	<i>1st Vice-President</i>	Saylesville
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DISTRICT SOCIETIES

KENT

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FENWICK G. TAGGART	<i>President</i>	East Greenwich, R. I.
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NEWPORT

Meets the second Thursday in each month

WILLIAM S. SHERMAN	<i>President</i>	Newport
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R. I. Ophthalmological and Otolological Society—2d Thursday—October, December, February, April and Annual at call of President. Dr. J. J. Gilbert, President; Dr. M. J. O'Connor, Secretary-Treasurer.

The R. I. Medico-Legal Society—Last Thursday—January, April, June and October. Dr. Creighton W. Skelton, President; Dr. Jacob S. Kelley, Secretary-Treasurer.

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ROBERT T. HENRY	<i>President</i>	Pawtucket
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PROVIDENCE

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WASHINGTON

Meets the second Thursday in January, April, July and October

M. H. SCANLON	<i>President</i>	Westerly
WM. A. HILLARD	<i>Secretary</i>	Westerly

WOONSOCKET

Meets the second Thursday in each month excepting July and August

T. J. McLAUGHLIN	<i>President</i>	Woonsocket
WILLIAM A. KING	<i>Secretary</i>	Woonsocket

EDITORIALS

THE STUDY OF PHYSICS IN PREPARATION FOR MEDICINE

At this season, editorial writers are accustomed to dwell on the advantage to the physician of some special branch of study. Mathematics, history and ancient languages are the subjects most often recommended. Ancient languages are constantly becoming of less importance in medical education. At present, the physician can obtain in a few hours

all the knowledge of ancient languages that is likely to be valuable or important in his work. History teaches the advantage of the use of reason over blind confidence in precedent or custom. It broadens vision and favors advancement. It is of particular value in the education of the medical mind. The study of mathematics is in itself of little advantage to the physician. Considered as the source of natural philosophy, mathematics is the foundation of medical science. Physiology rests on physical chemistry, this in turn, on natural philosophy, and natural philosophy, on the broad base of mathematics.

The importance to medicine and surgery of a comprehensive knowledge of physics can not be overestimated. The circulation of the blood, with the action of the cardiac pump, the movement of the blood stream through the arteries and veins and the various interchanges through the capillary walls, presents problems entirely physical. The respiration, with movements of the thorax and diaphragm, the diffusion of oxygen and carbon dioxid and the interchange of these gases between alveolar air and the pulmonary blood, depends on physical principles. The internist uses physical and mechanical instruments for diagnosis and the effects of light, heat and electricity in treatment. In the specialties, physics is of the greatest interest. The surgeon is constantly dealing with physical problems which are not fixed but are ever changing. A fundamental knowledge of physics is essential to his success. The work of the orthopedic surgeon depends almost entirely on physics. The action of healthy and diseased joints, the leverage of fractured or whole long bones and the mechanism of fixation are physical problems. The orthopedist constantly finds new problems which only an acquaintance with physics can enable him to rightly solve. The eye is an instrument for recording light vibrations. The ear intercepts the vibrations of the air which are recorded as sound. Refraction is a problem entirely physical. The middle ear, with its vibrating drum and chain of ossicles for transmitting the vibrations, is a beautiful machine, the action of which can be thoroughly comprehended only by one skilled in physics. The value of the physician in the community depends more upon his knowledge of physics than on any other branch of science.

STUDENT HEALTH

With the fall opening of schools and colleges it is appropriate for parents to consider health conditions in the institutions where their children are being trained. As far as the public schools are concerned health conditions in most communities may be said to be excellent. Careful inspection, prophylactic vaccinations, school doctors and nurses, the training of teachers and surroundings made hygienic by careful study on the part of the public authorities help to render the child's environment as safe as possible during school hours.

In boarding schools and the colleges the situation is quite different. Here the student is for long periods out of his home environment and a greater degree of responsibility for the safeguarding of his health rests upon the institution which is for the time being his home. In all matters of illness where quick decisions are necessary the school authorities of a boarding school stand in "loco parentis" and must act without delay. In such an institution a well equipped infirmary, a graduate nurse and the services of a well trained physician must be available. In other words the school must stand ready to furnish medical treatment for its scholars—subject of course to the direction of the parent when emergency conditions do not obtain.

The problem of student health at the college or university is a different one. Here we are dealing with young men or women approaching maturity and at an age when they are, or should be, to a great extent managing their own affairs. It is the duty of the college to furnish a healthy environment, to examine its students regularly to prevent their undertaking tasks or recreation for which they are not physically fit, to protect the healthy student by early detection and isolation of infectious diseases and to provide a means of caring for emergencies. It is also the duty of the college to present a certain amount of instruction to the student in matters of general and personal hygiene. It is much better, however, for the college authorities, not to take any responsibility for the furnishing of medical or surgical treatment to the students if the means of obtaining such treatment is available in the community. There is no more reason why a university should provide medical treatment than food or clothing, and the student should be left free to act independently in these matters though always able to obtain advice from the Medical Department of the university if he desires it. Every properly equipped college or university possesses a medical or health department whose duty it is to carry out the measures described above. The American Student Health Association is made up of representatives from the medical departments of more than a hundred colleges and universities throughout the country, has been functioning now for several years.

As a result of the activities of this organization much progress has been made in solving many of the problems which arise in this field. The net result of the whole development of college medical

departments is that the individual student is today many times safer in his undergraduate life than he was twenty years ago.

VACATION IMPRESSIONS

Presumably all wise physicians have taken a summer vacation. Some of us have in the past gone on the assumption that if we enjoyed our work we could work all the time and needed no vacation, but those of us in Rhode Island have seen some tragic examples of the fallacy of this idea, and know that a respite from our work and from contact with sick folks brings us back to our task better able to do good work. In addition to this general release from the pressure of work, we should on our vacation meet new friends, see new places and have some time for calm contemplation of a philosophy of life.

As one visits various parts of New England or neighboring states and countries, one finds the road filled with automobiles dashing here and there; some of these automobiles, to be sure, are going to camps and beaches where their occupants will settle down for real relaxation, but the general impression gained is that this age of hurry is leading people to dash madly about, boast of the miles covered and all the different places visited. On a trip to Maine, the writer left a town in northern Maine at the same time a buckboard drawn by two horses left; the automobile and the buckboard had the same destination; it took the automobile two and one-half hours to make the trip—it took the horses two and one-half days to make the same trip. One could not help but wonder whether the modern age, with its rapid transportation, with its running on schedule and its general wear and tear, did not involve certain dangers to our nervous systems, as well as our digestive systems, that made the older method of traveling have many compensations. As one got away from the beaten tracks into the heart of the woods and looked out upon mountains and lakes in their calm majesty, a certain restoration of viewpoint was gained, and the peace and quiet of nature seemed to allay the hurry and worry of our modern life. Would not the physician do well to teach his patients the value of simple things, the dangers of speed, and the wisdom of a close contact with nature. If we are to continue to add years

to the span of life, to gain a better sense of values and to maintain the best degree of health, isn't it time for us to align ourselves with the forces that teach a more sane living and an appreciation of the lessons provided all about us in the repose of mountains, lakes and rivers. Then, perhaps, we can do away with some of our sleeping potions, some of our digestive mixtures, and realize that we are surrounded with the healing forces of nature if we will only avail ourselves of them.

SOCIETIES

THE RHODE ISLAND MEDICAL SOCIETY

The September meeting of the Rhode Island Medical Society was held September 1, 1927, at the Crawford Allen Branch of the Rhode Island Hospital, the Society being the guests of the Board of Trustees of the Rhode Island Hospital.

The meeting, with the President, Dr. Norman MacLeod, presiding, was opened at 12 o'clock by a demonstration of the methods of treatment of the inmates of the hospital by Dr. Roland Hammond of the orthopedic staff of the Rhode Island Hospital.

The President announced the following appointees to the New England Medical Council:

Dr. A. H. Harrington, for 1 year; Dr. Byron U. Richards, for 2 years; Dr. H. G. Partridge, for 3 years; and the President and Secretary ex-officio.

Dr. Peters, Superintendent of the Rhode Island Hospital, welcomed the members of the Society, and extended an invitation of a thorough inspection of the new hospital building.

The President announced that the New England Health Institute would hold its meeting at Providence, September 27th to 30th, and he urged as many members as possible to register for this meeting and to attend the sessions.

A vote of thanks was extended the Board of Trustees of the Rhode Island Hospital for the courtesy in inviting the Society to hold its meeting at the hospital.

Following the meeting, a clam bake was served in the shore pavilion.

Adjourned

J. W. LEECH, *Secretary*

WOONSOCKET DISTRICT MEDICAL SOCIETY

The officers of the Woonsocket District Medical Society elected at our last meeting are as follows:

President, T. J. McLaughlin.
 First Vice President, C. B. Barry.
 Second Vice President, W. A. Bernard.
 Treasurer, L. V. Conlon.
 Secretary, W. A. King.
 Counsellor, E. L. Myers.
 Delegate, N. S. Garrison.
 Board of Censors, T. S. Flynn, A. H. Monty,
 H. E. Gauthier.

WILLIAM A. KING, *Secretary*

HOSPITALS

THE MEMORIAL HOSPITAL

The following is a copy of the minutes of the Memorial Hospital staff meeting held September 1st:

"Meeting called to order at 9:00 P. M. by Dr. A. T. Jones, president pro tem., in the absence of President Dr. J. L. Wheaton. Record of attendance taken. Nine members present. Minutes of the previous meeting read and approved. It was voted to place in the records the committee appointed by Dr. Wheaton to attend Dr. Oulton's funeral and also the committee appointed to draw resolutions on his death.

"Committee to attend funeral: Drs. F. V. Hussey, G. B. McGraw, and H. B. Moore. Committee on Resolutions: Drs. A. T. Jones, E. A. Shaw and Wm. P. Davis.

"Flowers were sent to Dr. Oulton's funeral by the staff. Copy of resolutions on Dr. Oulton's death read and placed on file. Reports of various services read and cases discussed. Dr. J. L. Turner was elected treasurer of the staff to fill the unexpired term of Dr. Oulton. Meeting adjourned."

JOHN F. KENNEY
Secretary

BOOK REVIEWS

PRINCIPLES OF CHEMISTRY (Roe), C. V. Mosby & Co., publishers, covers a wide field in chemistry. The book treats in an elementary way of inorganic and organic chemistry, the chemistry of metabo-

lism and digestion, as well as vitamins and dietary requirements. Further there are exercises which furnish practical application. The book should appeal widely to the nursing profession.

EXAMINATION OF CHILDREN BY CLINICAL AND LABORATORY METHODS, by Dr. Abraham Levinson.

This book on the examination of children by clinical and laboratory methods is a comprehensive study with lucid explanations of the various common procedures which the pediatrician employs. Also he has included most of the difficulties of examination, both clinical and laboratory, which are encountered in the practice of pediatrics as compared to similar situations and procedures encountered by general practitioners and diagnosticians.

It is an excellent book for the medical student during his instructions in pediatrics, and it is a handy book for the general practitioner or pediatrician to have in his office or laboratory to refresh his mind concerning the many laboratory tests.

INTERNATIONAL CLINICS, Volume III, Thirty-Sixth Series 1926. Philadelphia and London. J. B. Lippincott Company.

This volume contains a series of subjects dealing on, first, diagnoses and treatment; second, on neurology, psychiatry, and third, on surgery. Of practical importance to general practitioners is that on "Discharge Convulsions." Of considerable interest and speculation is that on radio-ionic medication of uranium.

The volume ends with notes on European medicine and medical education, with special reference to conditions existing in Italy, and with a brief but well written biography on Sir Clifford Albert by Sir Humphreys Rolleston.

INTERNATIONAL CLINICS, Volume I, Thirty-Seventh Series 1927. Philadelphia and London. J. B. Lippincott and Company.

This volume contains articles on diagnosis, treatment, medicine, surgery, bibliography, progress of medicine for 1926, and on cumulative index. Among the outstanding features of this volume are the clinics by Prof. Barker on diabetes mellitus, by Prof. Dean Lewis on surgery, by Prof. Sauerbruch of Germany on thoracoplasty and by Prof. W. Babcock on biliary surgery. The volume ends with an extensive treatise in the progress of medicine for 1926 by H. Cattell, M.D., and James Coupal, M.D.